

DEPARTMENT OF SOCIAL SERVICES

Date

THIS DOCUMENT MUST BE
MADE AVAILABLE FOR REVIEW
ON THE FACILITY PREMISES

● _____
Licensee

Name of Facility

Facility No.

Address

City, State, Zip Code

Waiver:

☐ Denied☐ Granted

SUBJECT: Waiver Request

Discussion and/or Limitations of Waiver (Reason for Denial):

This Waiver is subject to periodic review and may be
terminated at the discretion of the licensing agency.

Authorized Signature
Community Care Licensing Division